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ABSTRACT

This report examines the current status of child health services in the United States and identifies priorities for an improved health care program for mothers and children. Its recommendations are designed as guidelines for constructive discussion by participants in the 1970 White House Conference on Children. A major thesis of the report is that the existing child health system in the United States is costly but cumbersome, well-intentioned but deplorably piecemeal, a system which muddles along rather than moving forthrightly ahead. In the 1970's, we shall be responsible for meeting the health needs of an anticipated 100 million young people at various stages of development. The Forum members have concluded that nothing less than a rationally planned and soundly supported maternal and child health program can be expected to correct current inequities and inadequacies. Specifically recommended are: (1) a federally-financed national child health care program, (2) augmentation of illness prevention and health promotion services, (3) revitalization of certain existing child health program, (4) the establishment of a unified child health unit within the Department of Health, Education and Welfare, under a newly created Deputy Assistant Secretary, and (5) ongoing advocacy of child health programs, through a presidential council. Two papers are attached which compare various proposals for national health insurance. (Author/NH)

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Report of Forum 11

1970 White House Conference on Children

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for

THE 1970 WHITE HOUSE

CONFERENCE ON CHILDREN

Washington, D.C.
December 1970

*At the request of the Chairman, this has not been edited.

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FORUM 11: DELIVERY OF CHILD HEALTH SERVICES

Summary Statement

This Forum is convinced that a federally-financed, national child health care program needs to be developed and established promptly, and, to be effective, must be implemented aggressively.

Prior White House Conferences, attempting to fulfill charges similar to the one we have accepted, devoted themselves primarily to information gathering. Ours is the task of closing the gap between what we know and what we do. We know a great deal more about health maintenance, prevention of illness and disability, and treatment of disease in childhood than we did when the first White House Conference was called. We know more than we did 20 years ago about the normal developmental phases of childhood and youth, physically, intellectually, emotionally. We are infinitely more aware than we were 10 years ago of the relationship between a child's health and his total environment--family income, parental education, quality of nutrition, housing, stability of family relationships. The gap between what we know and what we do is growing wider and there is increasing public uneasiness about this gap. Everything we have learned must be placed at the disposal of all children--no matter where they live nor what their racial or ethnic origin nor how disadvantaged the homes in which they are being reared.

Debate has been initiated among various concerned segments in the country about national health insurance programs. A number of alternative approaches have been proposed and are currently in the process of review, consideration, and reformulation. These approaches include:

a) an extension of Medicaid, with adherence to national standards and with provision of federal financing;

b) voluntary health insurance in a variety of formats, including proposals developed by certain private carriers, one which would be financed by income tax credits, and one patterned after the Federal Employees Health Benefits Program;

c) social insurance programs, several of which have been formulated as legislative proposals.*

Our concern here is not to evaluate the relative merits of any of the proposed programs. Since each of them is subject to modification, our responsibility is to make clear the ways in which they should meet the health needs of children and youth.

It seems to us that all of the proposed programs neglect the specialized services which many children need--services such as early case finding, special care for high-risk new borns, mental health services, services for handicapped children and child protection services.

Nor do any of the programs come to grips with the special problems of providing adequate health services to populations in rural areas where there is absence or maldistribution of resources, where geographic distances make limited resources virtually inaccessible, and where there is little economic or political power to correct these deficits.

* See Attachment #1, National Health Insurance: A Comparison of Five Proposals; Attachment #2, National Health Insurance: A Matter of Importance in the 70's.

We are aware of the contradictions of proposing a program of health care for children, since we do not perceive them as separate consumer entities, isolated from their families. We would be reluctant to further fragment services which desperately need to be bound together as an integrated whole. We do not advocate a separate health policy for children nor separate resources for health services. Our proposals for children and youth are advanced within the context of a total family health care system. We are special pleaders only in the sense that we feel children must come first.

In 1969, this country spent $8.4 billion for personal health care for persons between the ages of 0-18; of this total, more than $2.2 billion was spent on government-supported programs. We are not prepared to say that higher total expenditures are called for, but it is evident to us that despite the money spent there were inequities and inadequacies in the availability of care. Adequate financing is important, but money alone will not solve the problems we face. We must be willing and ready to change traditional ways of dealing with sickness and health.

We recognize that the health needs of children in poverty are more urgent and more generally neglected than those of other children. But this urgency does not mean that the needs of the poor should be met haphazardly, or in terms of sheer expedience, or in any way that compromises quality.

We believe that society should take the initiative in seeing that the health needs of children are met. Children cannot speak for themselves nor seek out what they need. Not all parents are able to act to safeguard

the health of their children. Just as we have a formal policy and official measures for enforcing compulsory education for children, we must be aggressive and diligent in making sure that children use the health services that are available.

Specific recommendations of this Forum are:

1. That a federally-financed national child health care program be developed and established promptly and implemented aggressively; such a program should be compatible with a developing national health policy covering the total population and should provide a pluralistic approach.
2. That Sources of primary care be augmented through organized health care delivery systems devoted to illness prevention and health promotion; and that the federal government allocate a proportion of its budget for child health expenditures to serve as capital funds for the development of these systems.
3. That all health services for children (primary, secondary, tertiary) be rationally planned and allocated on a regional basis.
4. That certain existing health programs for children be continued, revitalized, given financial support which will enable them to function at full capacity and that these programs be effectively related to newly organized delivery systems.

5. That the current disarray and dismemberment of child health services within the Department of Health, Education and Welfare be corrected; and that a single strong unit be established under the leadership of a newly created Deputy Assistant Secretary whose prime concern shall be child health.
6. That there be ongoing advocacy at the top policy level for the social, physical and emotional well-being of children and, to this end, that a Presidential Council of Advisors on Children be created.

The following report documents the need for a national child health program, pinpoints the criteria which such a program should meet, and elaborates on the foregoing recommendations.

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I. The Need

There are 55 million children in this country under 14 years of age. It is estimated that in this decade there will be 4 million new births each year. We can expect, then, that in the 70's, 100 million different children will, at different stages of their development, be in need of health services.

These children are the nation's most treasured resources. We cannot afford to continue to let them enter a health care system as woefully inadequate as the one now offered them. Safeguarding the health of all the nation's children is not only humane, prudent, and compassionate; it is mandatory in the nation's best interests.

The total health services system in this country has been under critical scrutiny in recent years. Study after study has reiterated that services are too often fragmented, discontinuous, far from ideal in terms of availability and accessibility, hobbled by health manpower problems, and frequently delivered with little concern for the consumer's preferences, his understanding, his convenience, or even his personal dignity. This cumulative recitation of deficits has provoked widespread response--from the consumer, from health professionals, and from government leadership. Some improvements have been made and other more far-reaching changes are on the way.

The shortcomings of our current health care system have grave implications for the entire population. For children, whose future well-being and even survival are at stake, the implications are catastrophic.

The bill of particulars which could be drawn up is virtually endless. A few instances will highlight the urgency of the situation:

-- This country's infant mortality rate (21.8 per 1,000 live births in 1968) is higher than that of twelve other developed nations in the world. Variations within the country are even more significant, ranging from 16.9 in North Dakota

to 35.5 in Mississippi. Tha rate is almost twice as high for non-whites (many of whom live in environmental deprivation) as for whites. Within a single large city, infant mortality varies from 27 per 1,000 among the lowest socioeconomic groups to 16 per 1,000 among the higher groups. Factors contributing to infant mortality include: pregnancies among girls under 17, short interval conceptions, absence of prenatal care, lack of adequate diet during pregnancy and throughout life up until pregnancy, smoking during pregnancy, excessive restriction of weight gain during pregnancy, especially among underweight women and pregnant adolescents. These factors are all preventable.

-- We are far short of our goal of immunizing children against diseases for which protection has been developed. Almost half the under-19 population has not been adequately immunized against diptheria-pertussis-tetanus. Fewer than 75 per cent of persons in the same age group have been immunized against rubeola. The percentage of children ages 1-4 who are fully immunized against poliomyelitis has fallen from a high of 87.6% in 1964 to 67.7% in 1969.

-- Half the children in the country under age 15 and 90% of those under age 5 have never been to a dentist.

-- There is evidence to show that less than half the children needing mental health services are receiving them.

-- Malnutrition threatens many children from the moment of comception, and if that malnutrition persists during the first five years of life, the child is doomed to foreshortened physical and mental development, increased susceptibility to infection, and impaired response to his environment.

-- Approximately one million children are born each year to mothers who fail to get medical care during pregnancy and receive inadequate obstetrical services during delivery; these children are particularly vulnerable to problems

in the perinatal period.

-- An estimated 10 to 20 per cent of all children in this country suffer from chronic handicapping conditions; there is reason to believe that at least one-third of these conditions could be prevented or corrected by appropriate care in the pre-school years, and continuing, comprehensive care up to age 18 would prevent or correct as many as 60 per cent of these conditions.

Many of these appalling deficits have existed for a long time, and have been cited again and again. We do not believe that this pattern of reiteration need necessarily generate despair. We have indeed made significant progress in a number of areas, but our population growth and our rising level of expectations with respect to health care have outrun our accomplishments. Timing is of the essence, and we are convinced that now is the time for action.

We do not come to this task empty-handed. Many excellent health care programs are now available, offering some services to some children. Federal programs which have enormous potential for children include Medicaid, the Maternity and Infant Care and Children and Youth projects, State Maternal and Child Health and Crippled Children's Services, Neighborhood Health Center Programs and health services developed in support of Head Start Programs.

These public programs are divided among a number of governmental jurisdictions, and are competitive for both funds and manpower. To a significant degree, they suffer from dismemberment of agencies within the Department of Health, Education and Welfare which are concerned with child health services. The Children's Bureau, the establishment of which was one of the significant accomplishments of the first White House Conference, has been divested of its power and no longer speaks authoritatively and effectively on behalf of child health. Furthermore, child health programs are divided in such a manner in the

federal establishment that there is little liaison between research activities and service programs and no coordinated working relationship among the service components.

Despite the disadvantages under which the federal child health establishment currently operates, a number of its existing programs have yielded constructive experiences in the delivery of services which could be applied to a wider base. In addition, some state and local voluntary health agencies serve children and their families, although admittedly in ways that far from match the needs.

But none of the existing programs delivers all of what is needed to all children who need it. Some of the gaps are immediately apparent. For example, there is now no systematic way of charting the health needs of a child from the time he leaves the hospital a few days after birth until he enters the school system. Many children arrive at school without having ever received medical and dental supervision, and often with unrecognized, correctible defects. These are casualties of our hit-and-miss system. A second group of candidates for sustained neglect are children of the "near poor"--families who do not qualify for many of the publicly funded programs and yet whose own financial resources can buy care only for crisis situations. And even families whose budgets can accommodate continuing health care for their children are plagued by fragmentation of that care, unpredictable availability of health manpower, and the prospect of insupportable catastrophic illness.

Our need, then, is to provide <u>all</u> health services to <u>all</u> children, and to make sure that <u>each child uses</u> what is available and needed.

II. Program Criteria

Nothing less than a rationally planned and soundly supported national child health program will correct the inequities and inadequacies of the system we now have--a system which is costly but cumbersome, well-intentioned but deplorably piecemeal, a system which muddles along rather than moving forthrightly ahead. The following guidelines for such a program are herewith proposed.

1. A program should adhere to high standards of quality. We accept, as minimum requirements, the standards which have already been developed by the American Academy of Pediatrics; these encompass such factors as training, peer review, supervision of allied health personnel, adequacy of facilities, and optimum utilization of current knowledge.

Some aspects of health care can best be evaluated only by other professionals, who are qualified by training to assess the technical dimensions of the problem and make judgements about how appropriately it has been handled. There is, in addition, a valid role for the consumer of health services in judging the quality of care. Though the consumer may not have the capacity to evaluate the specifics of treatment, he can react to the total health delivery system, its convenience and accessibility, and the extent to which it responds to his expressed needs. In the past decade, there has been a marked upsurge of consumer participation in health care systems. Consumers have become increasingly sophisticated with respect to the organization of health care, and increasingly insistent that their participation be more than token.

There has been a dramatic and warranted thrust during the past decade behind programs for children living in poverty. There has perhaps also been

a tendency, as experimental programs have been developed, to use the disadvantaged as subjects rather than as patients. This is reinforced by the traditional practice of utilizing the poor as case material for medical teaching and research. The program we envision as the end-product of our national effort will neither by-pass the self-supporting family nor focus exclusively on the poor. Its goal is to provide services which are of equally high quality for all.

2. A program should provide a comprehensive range of services. Comprehensive health care involves many professional disciplines and a variety of facilities and services. It calls for the joint efforts of providers of primary care, specialists, subspecialists; the support of allied health personnel; the physical and financial availability of diagnostic facilities and of treatment resources.

Preventive services and early case-finding are the inevitable focus for child health services, since children are dramatically responsive to preventive care. Preventive components of the program should include immunization; health education for both children and parents; periodic screening for specific developmental and nutritional problems; and skilled anticipatory guidance.

Interventive services involve providing treatment for the ill and the injured. This includes both acute and chronic conditions, with particular attention to conditions which might result in death or in long-term physical and emotional impairment. Provision for interventive services should encompass outpatient treatment, a range of inpatient facilities (including further exploration of extended care facilities) and home-care with adequate professional and paraprofessional back-up.

Preventive and interventive services must be augmented by rehabilitative and supportive services. Rehabilitation programs should be placed at the disposal of disabled children who require specialized treatment settings in order that they can be restored to normal function, or, failing that, their disabilities can be minimized. Support services would involve not only the traditional ones such as social service casework, but should have new components which come to terms with today's realities. For example, in the network of day care centers now expanding throughout the country, provisions should be made to offer organized health services to pre-school enrollees. Day care personnel should additionally be available to stay with children while the mother takes an ill sibling to the doctor, or while the mother herself goes to a doctor or is hospitalized. Support services should include outreach which will engage in "patient pursuit"--that is, will seek out those children whose parents are unaware of existing services or are indifferent to them, and to make sure these young patients "connect" with the service.

One final factor should be mentioned within the context of comprehensive health care. We are well aware that it takes more than health services to safeguard the well-being of children. It requires an improvement in the child's total environment--his education, housing, family income, his safety from abuse and assault, his accessibility to uncontaminated food and unpolluted air. This concern extends beyond purview of this Forum and becomes a common responsibility of the entire White House Conference.

3. <u>A national child health program should concern itself with the full patient continuum</u>.

Ideally, health services for children should be family-centered, since it is unlikely that even the best-served child will remain healthy in a home in which

health problems of other family members are undetected or neglected. The family unit is the logical medium through which to gain access to children; ultimately it is hoped that it will be possible to provide periodic evaluation of total family health and to develop a system that will assure the necessary follow-up care.

At a minimum, a program of health services for children should start with the health of the mother. There can be (and often is) a virtually unending cycle in which disadvantaged and poorly nourished mothers give birth to premature infants who, ill-favored from birth, grow up in poverty and start a new family with an equally unpromising outlook. Pregnant women who are considered to be at high risk must be identified and the risks reduced as drastically as possible through education, counseling and specific treatment. Perinatal care should include development of centers capable of handling obstetrical emergencies and intensive care units for newborns who require such care.

A segment of the patient continuum most likely to be neglected is the pre-school group. The new centers for delivering health services which, it is hoped, will emerge during the next decade should engage in energetic programs of outreach to insure that pre-school children are brought in for periodic assessment of their general health status, and prompt attention to factors which threaten to impair their physical, intellectual or emotional growth, immunization and prophylactic dental care. We consider the delivery of preventive services to this age group to be the top priority of our proposed national child health program.

The school-age child could advantageously receive more services than he now does from the school health system, provided the schools are not expected

(nor permitted) to go it alone, but are part of a network of human service agencies. Schools could extend and greatly increase the effectiveness of their present activities with respect to early case-finding, but there must be resources to which children can be referred for treatment fo health problems which are found. Schools can expand their efforts in health education, encompassing nutrition, family life education, drug abuse, mental health and environmental improvement. As the school-age child enters adolescence, he needs help in preparing for his own adulthood, in assuming some measure of responsibility for his own health and welfare, and in getting ready, emotionally and physically, for his ultimate role as a parent and a contributing member of society.

How to become and function as parents is one of the most important health education problems we face today. Family planning services are most rationally considered as an integral component of Maternal and Child Health Services, They deserve special consideration during adolescence, early adulthood and at the time of post partum care.

4. A national child health program should assure the accessibility of its services.

To meet family needs realistically, child health services should be available within easy geographic access to all families.

To the rather limited extent that they have been established, Neighborhood Health Centers meet the criterion of accessibility. It is possible that existing neighborhood institutions where consumers regularly gather (schools, day care centers, churches, community centers) can be used as sources for the delivery of certain preventive health services. They could certainly function usefully to direct their constituents to the most accessible sources of primary care--if such sources are provided by an organized delivery system.

Only when comprehensive outpatient facilities are effectively dispersed throughout neighborhoods will the consumer stop perceiving hospitals as the only source of treatment. Such accessibility will go a long way toward discouraging the current indiscriminate and inappropriate use of the hospital emergency room.

The problems of accessibility are infinitely more difficult to correct in the rural areas, where there is virtually no base upon which to build. Distance from resources is only one aspect of the problem; the resources themselves are very scanty, and in many areas there are no provisions even for emergency care, let alone sustained services for health maintenance. These deficits must be corrected.

5. A program will require a restructuring of the total health manpower resources.

There are not enough general practitioners and pediatricians in the country to meet current needs, as health services are presently being delivered, and certainly far from enough to carry out a program which will reach all children. The supply of general practitioners in the United states has been steadily declining. The number of pediatricians has increased four-fold during the past 10-15 years, but there has been a 30 per cent decrease in those going into private practice. All told, the physician/child ratio has dropped sharply.

We cannot solve the problem by asking doctors to see more patients or to work harder or faster. We must find other ways to increase the size and productivity of the total health manpower pool.

Physicians generally and pediatricians specifically tend not to be efficiently utilized. By the time a pediatrician has completed his specialty training, he has developed a level of expertise appropriate for a consultant and is over-trained for most of the requirements of daily office practice. The role of the pediatrician is currently being critically evaluated by both the

profession and the consumer and it is anticipated his function within the health care team will, in the years ahead, be sharply redefined.

One direction in which change is taking place is the increased use by physicians of allied health personnel. Many of the health care tasks now performed by pediatricians can be, and sometimes are, carried out competently and reliably by pediatric nurses. A more widespread extension of nursing responsibility to include assessment, preventive services, anticipatory guidance, instruction of parents, and patient follow-up should be explored. Nurses, too, are in short supply, and many of their traditional tasks could, in turn, be re-assigned to nursing assistants.

In addition to the recruiting and training of allied health personnel, we ought not lose sight of the potential uses of the indigenous aides who first emerged from innovative anti-poverty programs. They are particularly useful as credible liaisons between the patient and the professional in disadvantaged neighborhoods.

As the use of allied health personnel increases, we should make sure that they do not all gravitate toward health care centers in poverty neighborhoods, working, in some instances, under the part-time supervision of physicians, while all the physicians trained to the specialty level continue to concentrate in affluent neighborhoods. Equally well-trained manpower at all levels of prefessionalism should be available to all categories of patients.

Restructuring the health manpower pool will require correcting its present maldistribution. It has been suggested that recently trained physicians be assigned to tours of duty in the areas in short supply (urban ghettos and rural areas), very much as they are assigned to military duty. The point has been made that since many of these physicians obtained their professional training at tax-supported institutions, preempting of a few years of their professional

service in the public interest is entirely equitable, It has also been suggested that medical scholarships be granted with the explicit requirement that the recipient, when his training is completed, be available for assignment where needed. A number of other incentives have been proposed to divert trained personnel into undersupplied locales. These include: financial incentives, faculty appointments in nearby medical centers, and special opportunities for continuing professional education.

This sort of re-deployment of manpower should not, however, be undertaken as a stop-gap or a piecemeal measure. It makes little sense, for example, to send a newly trained physician into a rural area if he must refer his patients to remote and poorly equipped hospitals and if he has no professional back-up for specialty consultation. Re-allocation of health manpower can have meaning only if it is carried out within the framework of an organized delivery system, with adequate financial support.

Constructive revision of our health manpower system cannot be accomplished without exploration of changes in professional education, licensing procedures and other legal regulations relevant to the practice of the health professions. Finally, the accomplishment of these goals will call for demonstration by the health professions of their own sense of social responsibility in correcting the inequities which now exist.

6. <u>A national child health program must be stabilized by community planning</u>.

We can no longer afford the luxury of autonomy for providers of health services. The risks of duplication and overlap, of both under- and over-utilization are too grave. Planning, allocation and monitoring for all health facilities must be done in an orderly fashion, on a community, an area, or a regional basis.

Regionalization should aim to insure a rational distribution of sources for health care at various levels. Primary care would be available at the physician's office or at an outpatient facility, within reasonable travel time for the patient. Secondary care would provide specialized services to which the patient could be referred for the diagnosis and treatment of more complex problems; such care could be based in community hospitals. Tertiary care would involve the more sophisticated subspecialties directed to the less common disorders, and would be based in a medical center or a university teaching center. Here would be concentrated, highly specialized facilities whose random duplication would be extremely wasteful, for example intensive care units for high-risk newborns, and special units for open-heart surgery and organ transplants.

It has been suggested, as a horizontal rather than a vertical approach to community planning, that all human service facilities be geographically clustered. Such a cluster would include hospitals, outpatient resources, day care centers, social service and law enforcement units (to deal with such problems as adoption, foster home placement, child abuse, deliquency, etc.) so that there would be an uninterrupted flow of services to the child, a continuing corps of professionals in touch with the child, and a total record of what the child has needed and what has been provided.

Community planning provides yet another area in which the consumer can be heard and in which his immediate familiarity with the community can enrich the planning efforts. Although lay representation is frequently found on community planning bodies, it is traditionally restricted to representatives of the community power structure. True consumer representation should speak for all socioeconomic levels and--explicit to our area of concern--it should speak committedly for the well-being of children.

7. A program requires a reorganization of the delivery of health services. New delivery systems are necessary if we are to achieve a child health program of the scope and quality we advocate. In developing systems which depart sharply from current patterns, we do not want to capriciously dismantle all we now have, nor to liquidate the many commendable programs now being carried out for children. Rather, we should build on our existing strengths.

Changes in financing health care without changes in the delivery goal will not accomplish our goals. The experience of recent years has demonstrated that added money pumped into the present system drives up costs without augmenting resources.

In order to have the potential for correcting the inequities and inadequacies of the present delivery system, new systems should embody the following:

-- Better utilization of health manpower. This might call for more widespread use of health care teams, such as have been utilized in Children and Youth Projects, neighborhood health centers and in some community mental health programs. It might be accomplished through group practice, carried on in a variety of patterns. In any event, it will call for substantially more utilization of allied health personnel than has been customary.

-- Incentives for efficiency of operation. The systems should encourage prudent and discriminating utilization of its services. This implies greatly exp nded use of outpatient facilities and reduction of unwarranted hospitalizations, which are not only costly to the system but disrupting and traumatic to the patient. Even more significant in its implication for children, sound utilization practices will highlight preventive measures.

-- Payment to the provider of services on a prepayment rather than a fee-for-service basis, to enable the provider to budget rationally and to discourage further inflation of health care costs.

-- Availability of the same health care services, facilities, and personnel to the indigent and the non-indigent.

III. What Should Be Done

It is the opinion of the members of this Forum that the country is moving toward a more formalized national health policy. It seems feasible that such a policy be instituted in increments rather than as an all-encompassing program. Therefore, we urge that the nation's children be given first priority. The specific recommendations which are herewith presented are formulated on the premise that new systems for delivering health care to children should be incorporated into the mainstream of national policy and practices.

1. We recommend that a federally financed national child health care program be developed and established promptly and implemented aggressively.

The health of children is inseparable from the health of their families and indeed from the health of the total nation; accordingly, a national child health care program should be compatible with an emerging health policy.

The program will require a stable, permanent federal financing mechanism, possible through a combination of payroll taxes and general tax funds. This mechanism might be provided through the extension of Medicare to the target age group. In addition to the present practice of reimbursing providers on a fee-for-service basis, it should reimburse in a way which would create incentives for efficient and cost-controlled operations. We believe that a sounder model would be the Federal Employees Health Benefits Program. This program, which has been effectively providing health care coverage to nearly eight million persons for the past decade, specifies minimum benefits, maintains surveillance of the system and allows a choice among a limited number of prepaid programs including national Bule Cross/Blue Shield, national idemnity plan, prepaid group practice

and individual practice. Thus, the program promotes a system of controlled competition in which the consumer can choose from among a number of resources and can change from one to another at specified intervals. In extending such an approach, financial provision would be required (perhaps from general tax funds) to pay for benefits to children whose parents are not employed.

2. We recommend that sources of primary care be augmented through the creation of organized health care delivery systems.

New delivery systems, devoted to illness prevention and health promotion, could be organized under a variety of auspices; medical and dental schools, hospitals, private non-profit organizations, private profit-oriented organizations, governmental units, medical and dental societies, or consumer groups.

Establishment of new delivery systems will call for substantial financial assistance. It is suggested that all Federal programs providing health services to children allocate a specific percentage of their budgets as "front-end" money to help pay for the initial costs of these resources.

The network of new delivery systems should build on the health care organizations which already exist. Thus, government-sponsored neighborhood health centers could contract to provide services to groups of non-indigent persons, and prepaid group practice programs now in operation could contract similarly with the indigent.

The commitment of such a program would be to children of all ages and to their mothers. First priority, at the outset of the program, would be to children from the time of conception to age 5.

There would be no adverse selection with respect to enrollment in a delivery system. Total delivery systems, as well as specific services, would be subjected to periodic evaluation.

3. We recommend that all health services for children (primary, secondary, tertiary) be rationally planned and allocated on a regional basis.

Through the regionalization of health services for children, it will be possible to strengthen existing programs, correct weaknesses, make better use of health manpower, encourage a variety of services and competition among them, and overcome the inequities which result from the statutory restrictions imposed by individual states.

Those with the responsibility for this regional planning should be as concerned with promoting the establishment of new sources of service as with controlling and monitoring to prevent duplication. Its activities should be integrated with the new systems for delivering primary care.

There should be represented on such regional bodies the health professions, community leadership at all levels, the consumer, specifically--spokesmen for the well-being of children.

Regional programs can be expected to vary from each other in order to reflect each community's own needs and its own sense of priorities. An aggressive regional approach could provide a solution to the too-long-neglected problems of health care for rural areas.

The Maternal and Child Health Service of the Department of Health, Education and Welfare has already demonstrated the feasibility of regionalization through a series of vanguard programs which provide highly specialized services (for low-weight babies, children with limb deficiencies, infants in need of complex surgical procedures) through regional centers. This pattern might serve as a model for the more extensive regionalization we recommend.

4. We recommend that certain existing health programs for children be continued and expanded and that these programs be effectively related to the organized delivery systems.

Recognizing that the development of full-scale delivery systems of comprehensive health services will require an extended period of time, we are concerned that no children be deprived of existing services during the interim period. This is a particularly urgent consideration since, in many instances, recipients of these services are disadvantaged children whose parents are unable to procure health care from other sources.

State Maternal and Child Health Programs and Crippled Children Services, should be modernized and given continuing Federal support at a level which will enable them to function at full capacity. This support is needed so that these programs can provide needed technical assistance to community agencies, institutions and practitioners caring for children.

Two existing health programs for children (Maternity and Infant Care and Children and Youth projects) are now delivering comprehensive health services to disadvantaged children in a limited number of localities. Like many other Federally supported programs, they are conspicuously absent in rural areas and we urge that they be extended to these under-supplied communities. In communities where both these programs are being carried out, we recommend that they be consolidated. Ultimately they should be converted to full-scale health delivery systems, providing services to the non-indigent as well as the indigent.

5. We recommend that all Federally supported child health services be brought together in a single, strong unit within the Department of Health, Education and Welfare, and that such a unit be the responsibility of a newly created Deputy Assistant Secretary whose prime concern shall be child health.

We are concerned with correcting the disarray which now exists within the

department of Health, Education and Welfare, with respect to child health programs; with restoring to those programs the coordination they now lack; and with providing top-level leadership which a national child health program deserves and needs.

6. We recommend establishment of a Presidential Council of Advisors on Children.

There is need for ongoing advocacy at the policy level for the social, physical and emotional well-being of children. Such advocacy could be provided by a highly qualified and effective advisory council (comparable to the National Council of Economic Advisors) which could develop priorities and policies as they pertain to children.

This recommendation reaffirms a position already taken by the American Academy of Pediatrics, the Joint Commission on Mental Health of Children and by the American Public Health Association.

The advocacy which is needed extends beyond considerations of health alone and involves the entire range of issues being explored by this White House Conference. Accordingly, we request that all other Conference Forums join with us in sponsoring this particular recommendation.

DONALD CAMERON SMITH

RESEARCH and STATISTICS NOTE
U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social Security Administration
Office of Research and Statistics

Note No. 12--1970 July 23, 1970

NATIONAL HEALTH INSURANCE: A COMPARISON OF FIVE PROPOSALS *

Discussion concerning a national program of health care for the general population has increased in recent years. In the last year several important plans, representing widely different approaches to such a universal health program, have been proposed.

This Note is designed to meet the need for an objective description and comparison of the major proposals. For this purpose, five plans illustrating various approaches to a national program, all of which have significant sponsorship, have been chosen for analysis:

1) Griffiths bill (H.R. 15779)
2) Committee for National Health Insurance (Health Security Program)
3) Javits bill (S. 3711)
4) American Medical Association "Medicredit" plan
5) Pettengill-Aetna proposal

The five proposals may be described, broadly speaking, as based on an insurance concept and may be classified according to plans based primarily on social insurance principles and plans that emphasize maximum use of private insurance. The Griffiths and Committee for National Health Insurance proposals follow in the tradition of social insurance programs in that they are essentially universal for the groups covered, with the programs administered by government agencies and financed at least in part by social insurance contributions.

The AMA Medicredit and the Pettengill-Aetna proposals are based primarily on private insurance with coverage available on a voluntary basis, administration largely in the hands of private insurance carriers (supervised by government) and financing from private sources and governmental general revenues. The Javits bill incorporates elements of both these approaches. It provides for a universal Federal program based on social insurance financing but offers the alternative of "electing out" of the basic program by securing approved private insurance coverage.

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* By Saul Waldman and Evelyn Peel, Division of Health Insurance Studies.

The descriptions of the five plans summarize the major elements of the proposals relating to insurance against the costs of personal health care. Those parts of the plans relating primarily to such matters as the organization of health care services, methods of delivery of service, and medical manpower generally are not included. Some descriptions are longer than others, which mainly reflects the ease of explanation in describing them. The estimates of the costs of the various programs are those of their sponsors and, except where otherwise noted, these estimates (and the adequacy of the programs' financing provisions) have not been independently evaluated.

To assist in the comparison of the proposals, a chart summarizing the principal provisions of the plans is shown. Those interested in obtaining further information may consult the attached bibliography, which identifies the major sources of current information on national health insurance proposals.

GRIFFITHS BILL

The Griffiths bill was introduced in the House of Representatives on February 9, 1970, by Representative Martha Griffiths of Michigan. It has been endorsed by the AFL-CIO.

General approach

The proposal would establish a national health insurance program administered by a Federal Government agency and financed by payroll taxes and Federal general revenues.

Coverage

The program would cover all citizens of the United States and aliens who have one year residency. Members of the Armed Forces, but not their dependents, would be excluded from coverage.

Benefits

The proposal provides for comprehensive benefits covering nearly all types of recognized health services. The major service excluded is dental benefits for adults. Some types of benefits are subject to limitations and for some there would be a charge (copayment) to the patient. These copayments are subject to a yearly maximum of $50 per person or $100 per family. The major benefits provided would be as follows:

Physician services--Charge of $2 per visit except for annual physical check-up and one additional visit
Dentist services for children under age 16--Charge of $2 per visit after two annual check-ups
Optometric services and eyeglasses--Maximum allowance and conditions to be established by regulation
Other health practitioners rendering remedial care--Charge of $2 per visit
Hospital inpatient and outpatient
Skilled nursing home
Home health services--Charge of $2 per visit
Rehabilitation services
Prescription drugs
Prosthetic devices and durable medical equipment--Maximum allowances and conditions to be established by regulation
Ambulance services--Conditions to be set by regulations

Administration

Overall responsibility for administration of the program would be placed in a National Health Insurance Board consisting of nine persons, including three government officials and six nongovernmental members. The three officials would be the Secretary of Health, Education, and Welfare who would be chairman, the Assistant Secretary of HEW for Health and Scientific Affairs, and the Commissioner of Social Security. The six nongovernmental members who would be appointed by the President would include one member representing labor, one from management, one from providers of care, and three experts in medical care organization and administration.

The Board would receive advice from two advisory councils. One of the councils, the National Health Professions Council, would include 20 members representing providers of services including physicians, nurses, hospitals and nursing homes. The other council, the National Health Benefits Council, would include 20 members representing consumers including the working population, the poor, aged, children and minority groups.

Administrative regions would be established, headed by a Regional Administrator, who would be responsible for contracting with providers of care, adjudicating complaints, stimulating quality of care, increasing the supply of manpower and facilities, and other duties. Each region would have two advisory committees, one representing providers and one representing consumers.

Payments to providers of service

Groups of physicians who are organized into a plan (which could be a group practice plan or a plan sponsored by a medical society or a non-profit organization) could contract to provide medical services under the program. The group would receive payment on a negotiated budget (capitation) basis, and would receive an additional 5 percent for their administrative expenses. From the payment received, the group could remunerate its physician members on a fee-for-service, salary, or other basis. Similar arrangements could apply to groups of dentists.1/

Physicians in individual practice could, by agreement, arrange to be paid on a per capita basis, salary (full or part-time) or combination of methods. In these cases, the payment for physician services would be made to the primary physician and the physician would arrange and pay for the services of specialist physicians and other health professionals. Similar arrangements would apply to dentists.1/

Hospitals would receive payment on a negotiated budget or other approved basis. The payment to the hospital would include an amount enabling the hospital to take responsibility for providing, or arranging for, care in skilled nursing homes and home health and rehabilitation services.1/

Financing and costs

The program would be financed by a payroll tax of 1 percent on employees and 3 percent on employers and, in addition, a payment from Federal general revenues that would be equal to 3 percent of covered payroll. (A tax of 4 percent would be levied on the net earnings of self-employed persons.) The amount of earnings subject to the tax would be increased

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1/ Physician groups, hospitals and other providers of service could contract to provide, or arrange for, additional types of service (or for comprehensive covered services) in which case they would receive the combined per capita payment for these services.

(above that now taxable for social security purposes) in stages to $15,000 annually by 1975. Each year thereafter this earnings base would be automatically increased according to the rise in average wage levels. In summary, the income of the program would be approximately equal to 7 percent of covered payroll on a $15,000 earnings base, adjusted for increasing wage levels.

The AFL-CIO estimates the cost of the program in fiscal year 1969 would have been $35.8 billion, including 5 percent for administrative costs.

In July 1970, Mrs. Griffiths announced she will re-introduce a bill next year that would provide improved benefits and would levy a total tax of 8 percent of covered payroll, including 1 percent on employees, 3.5 percent on employers and a contribution from general revenues equal to 3.5 percent of payroll.

COMMITTEE FOR NATIONAL HEALTH INSURANCE

(Health Security Program)

The proposal, called the Health Security Program, is sponsored by the Committee (of 100) for National Health Insurance, a private educational organization that was founded by the late Walter Reuther and is now chaired by Leonard Woodcock. The final proposal was released to the public at a press conference on July 7, 1970.

General approach

The proposal would establish a national health insurance program administered by HEW and financed by a tax on payroll and nonearned income and by Federal general revenues.

Coverage

All United States residents, including aliens admitted as permanent residents, would be covered except members of the Armed Forces.

Benefits

Comprehensive benefits covering nearly all types of recognized health services are provided. The major exclusion is dental care for adults, but the intention of the proposal is to cover adult dental services as rapidly as the supply of dental manpower can be increased. Some services are subject to limitations as indicated in the listing below of the more important benefits.

Physician services
Dental services for children up to age 15; at later date for all ages
Optometrist services and eyeglasses
Podiatrist services

General hospital services
Skilled nursing home care (120 days of care per spell of illness)
Medical appliances (to be prescribed by regulations)
Home health services
Laboratory services and X-ray
Mental health care ("active treatment")
Prescribed drugs for treatment of long-term illness

Administration

The program would be administered by a five member Health Security Board reporting to the Secretary of HEW. It would provide a focal point for a coordinated National Health Program (including other major HEW health programs). Regional, sub-regional, and local offices of Health Security would be given strong discretionary power relating to determination of local and regional health priorities, payments to providers, development of facilities, and other matters.

A Health Security Advisory Council, with a majority of consumer representatives, would advise the Board and would report to Congress on the status of the program. Separate advisory councils on drugs and dental services would report on problems concerning these benefits. The Board would have responsibility for assuring consumer representation at all levels.

Payment to providers of services

All providers would receive payments on the basis of budgets designed to pay reasonable cost under efficient operation. At the start, the budget would be based generally on the present services of the provider; future changes in the scope of services will be dependent on planning approval.

The payment to physicians would be based on a sub-regional fund for physician services in an amount determined by the size of the population modified by various relevant factors. Physicians may choose to be paid on a fee-for-service or (for primary physicians) capitation basis, or with approval of local administrator, by full-time or part-time salary, per session, per case, or combination of methods. The region would first allocate the funds needed for physicians in group practice and those on a capitation, salary or per session basis.

The residual of the fund would be allocated to local payment authorities designated by physicians (for example, a Blue Shield plan or a local medical society) which would have the financial responsibility for paying physicians who selected fee-for-service or per-case payment. Dentists, optometrists and podiatrists would be paid on the same basis as physicians.

Comprehensive group practice organizations could choose to be paid on a capitation or budget basis and would be eligible to receive additional amounts up to 3 percent of costs to use at their own discretion. Independent laboratories would be paid on a fee, budget or other contract basis.

Hospitals, nursing homes and home health agencies would be paid on the basis of negotiated budgets.

Financing and costs

The income of the program would be derived as follows: 35 percent from a tax on employers, 25 percent from a tax on employees and on nonwage income ordinarily subject to Federal income tax, and 40 percent from Federal general revenues.

On the basis of fiscal 1969 costs, total taxes for the program would be equal to about 7 3/4 percent of covered income and would consist of (1) a payroll tax of 1.8 percent on employees and the self-employed on the first $15,000 of earnings and a tax at the same rate on the first $15,000 of nonwage income, excluding the first $400 of such income, 2/ (2) a payroll tax of 2.8 percent on employers' total payroll, and (3) a contribution from Federal general revenues equal to approximately 3.1 percent of the covered income.

It is recognized that the tax rates may need to be changed when the program goes into effect, depending on the increases which occur in medical care costs and in the income subject to the taxes of the program.

The Committee for National Health Insurance estimates the cost of the program in fiscal year 1969 would have been $37 billion including administrative expenses.

2/ Only the first $15,000 of income from earnings and nonwage sources combined would be subject to tax.

JAVITS BILL

The Javits bill (S. 3711) was introduced in the Senate by Senator Jacob Javits of New York on April 14, 1970.

General approach

The proposal would establish a national health insurance program, based on expansion of the Medicare program to the general population, but with an option to "elect out" of the government program by purchase of approved private insurance.

Coverage

The Medicare program for the aged would be extended to disabled persons effective July 1971, at which time the premium payment required of beneficiaries under medical insurance provisions of Medicare would be eliminated. The program would be extended (effective July 1973) to the general population, including citizens and aliens admitted for permanent residence.

Benefits

The benefits of the proposed program would be the same as under the present Medicare program, with some additions phased in at a later date. The present Medicare benefits are as follows:

Hospital inpatient care--Ninety days of hospital care in each benefit period, plus a "lifetime reserve" of 60 days, subject to the following cost-sharing provisions: an annual deductible per person of $52 and coinsurance of $13 per day for the 61st to 90th day of care and $26 per day for additional covered days.

Skilled nursing home--One hundred days of care, after a hospital stay, subject to coinsurance of $6.50 per day after 20 days.

Home health services--One hundred visits after hospital or nursing home stay (no cost-sharing)

Physician services)
Hospital outpatient)
Laboratory and X-ray) $50 annual deductible per person
Medical appliances) and 20 percent coinsurance
Home health services (100 visits))
Physical therapy)

The additional benefits to be added to the program would be phased in as follows:

Drugs--Long-term maintenance drugs for diabetes, chronic cardiovascular disease, kidney conditions and respiratory conditions would be added effective July 1973. These drug benefits would be subject to a copayment of $1 per prescription and this amount would be adjusted each year for changes in drug prices.
Annual physical examinations and eye and ear examinations (effective July 1974)
Dental care for children under age 8 (effective July 1974)

Administration

As under the present Medicare program, responsibility for administration of the program would be given to the Department of HEW. However, State governments, by agreement with HEW, could arrange for administration of all or part of the program.

As under Medicare, the processing of claims for benefits would continue to be delegated to private insurance carriers under contract with the Department of HEW. However, as an alternative under certain conditions, the Secretary of HEW would be authorized to establish a public corporation to process claims in one or more areas.

Payments to providers of service

Until June 1973, reimbursement of providers of service would be on the same basis as under the present Medicare program; that is, hospitals and other institutions would be reimbursed on the basis of reasonable cost and physicians would receive payment based on reasonable charges. After that date, a new reimbursement method would be established. According to the bill, this new method, to be developed by the Secretary of HEW after consultation with advisory bodies, would be designed to control cost and utilization and improve the organization of medical services but would not deprive providers of fair and reasonable compensation.

The proposal, which includes various incentives for the growth of comprehensive health care service systems, provides that these organizations could enter into contracts with the Secretary and be permitted to receive a share (limited to two-thirds) of savings they produce for the program.

Financing and costs

The program would be financed by a payroll tax of 3.3 percent on employees on the first $15,000 of annual earnings (with an equal tax for the self-employed), 3.3 percent on employers' total payroll and a Federal government contribution from general revenues equal to 3.3 percent of covered earnings. The total income to the program would therefore be equivalent to about 10 percent of covered earnings. According to the Chief Actuary of the Social Security Administration, the cost of the program in 1975 would be $66.4 billion.

Optional insurance plans

As an alternative to coverage under the national program, the bill would permit employee-employer plans to serve as an alternative to coverage under the government program. To qualify under this provision, the plan would have to provide benefits superior, in terms of actuarial and health care considerations, to those of the national program and include provisions for covering the dependents of the employee. The employer would have to pay at least 75 percent of the cost of the plan.

Another alternative to government coverage is included in a provision that would permit individuals to "elect out" by purchasing approved private coverage. Such approved insurance, which could be offered by private carriers under contract with the Department of HEW, would have to provide equivalent health protection at no greater cost.

Employers, employees, and other individuals covered by optional insurance are exempt from the regular health insurance tax.

AMA MEDICREDIT PROPOSAL

The Medicredit proposal, which is sponsored by the American Medical Association, was presented by Dr. Russell B. Roth on November 3, 1969, before the House Ways and Means Committee.

General approach

Tax credits would be provided against individual income taxes to offset the premium cost of private health insurance voluntarily purchased by the taxpayer. The amount of credit would be graduated with the larger credits available to lower income groups.

Coverage

All families and individuals potentially subject to individual income tax, except members of the Armed Forces, could elect to be covered on a voluntary basis. Persons age 65 and over would remain under Medicare and be eligible to obtain tax credits only for supplementary coverage.

Benefits

The maximum amount of credit available would be an amount equal to the total premium cost of a "qualified" health insurance policy. The amount of credit granted would be graduated from 100 percent of the total premium for returns with a tax liability less than $300 to 10 percent of the premium for returns with a tax liability of more than $1,300. The credit would be taken on the regular income tax report. Persons with little or no tax liability would receive a payment voucher for purchase of insurance.

To be qualified, an insurance plan would have to provide the following basic benefits. The average premium for basic benefits would be about $219 for an individual, $429 for a family of two and $663 for other families, according to the AMA.

Hospital inpatient care--Sixty days of care subject to a $50 deductible per person
Hospital outpatient and emergency room service, subject to 20 percent coinsurance of first $500 of expenses (in effect, a maximum of $100)
Physician service, subject to 20 percent coinsurance of first $500 of expenses (in effect, a maximum of $100)

In addition, on an optional basis, the following supplementary benefits may be included in a qualified policy:

Prescription drugs, subject to an annual $50 deductible per person
Additional hospital days, subject to 20 percent coinsurance
Cost of blood in excess of 3 pints
Other personal health service furnished under the direction of a physician, subject to 20 percent coinsurance

Administration

The program would be supervised by a Health Insurance Advisory Board consisting of 11 members including the Secretary of HEW (chairman), the Commissioner of IRS, and 9 nongovernmental members. The Board would establish regulations for administration of the program and would establish Federal standards for determining whether an insurance plan is

qualified. Using these standards, the State insurance departments would approve the insurance plans. They would also approve the premium rates to be charged.

Payment to providers of service

There would be no change, as a result of the plan, in the methods by which insurance carriers pay providers of service.

Financing and costs

The cost of the plan would include the loss of revenue to the Treasury attributable to the tax credits and the expenditures for payment vouchers. The proposed plan does not include any special provisions for financing the cost.

The AMA estimates the gross cost of basic benefits for the plan in 1970 would have been $14.6 billion and the net cost, after adjustment for reduced Medicaid expenditures, $12.1 billion, if all persons took advantage of the credit for which they are eligible. On the assumption that some persons would not use their credit, the final AMA estimate is given as $8.3 billion.3/

A research report on the tax credit approach issued by the Office of Research and Statistics of the Social Security Administration estimates the gross cost of the basic benefits of the plan for 1970 would have been $18.0 billion and the net cost $15.3 billion. These net cost estimates are adjusted for the reduction in Medicaid expenditures and reduced medical expense deductions on income tax returns.4/ No estimates of the cost of the supplementary benefits are available.

Recent revisions

As of June 1970, the AMA House of Delegates has approved some revisions in the Medicredit proposal, the most important of which are the following: (1) For those entitled to a maximum tax credit (i.e., those with a tax liability of less than $300) there would be no deductibles or coinsurance provisions in the health insurance policy. (2) For the hospital inpatient benefit provisions, two days of care in an extended care facility could be

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3/ The estimates were given by Dr. Russell B. Roth in testimony before the Ways and Means Committee on November 3, 1969.
4/ Saul Waldman, "Tax Credit for Private Health Insurance: Cost Estimates for Alternative Proposals for 1970," Medical Care, J.B. Lippincott Company, Philadelphia, September-October 1970.

substituted for one day of eligible hospital care. (3) A catastrophic coverage benefit is added which would cover all hospital and medical costs after the first $300 paid out-of-pocket (i.e., not covered by insurance) by the individual, up to an additional maximum of $25,000. The benefit would be part of the supplementary benefit package and subject to coinsurance. (4) Provision is included for review of utilization, charges and quality of services rendered by providers of service. Disciplinary action, including suspension or exclusion from the program, could be imposed under specified procedures.

NOTE: Tax credits for private health insurance would also be provided under two identical bills introduced in the present session of Congress--H.R. 9835 by Representative Fulton of Tennessee and S. 2705 by Senator Fannin of Arizona. These bills differ from the AMA Medicredit proposal mainly because (1) the maximum tax credit is a specified amount (i.e., $400 for a family) rather than an amount based on the cost of a qualified policy and (2) the amount of tax credit is graduated based on adjusted gross income shown on the tax return rather than the amount of tax liability.

PETTENGILL PROPOSAL

This proposal was presented by Daniel W. Pettengill, Vice President of the Aetna Life and Casualty Company, on behalf of the Company on November 6, 1969, before the House Ways and Means Committee.

General approach

Among the proposals advanced by Mr. Pettengill to improve the availability and financing of health services are three recommendations which, taken together, would bring into effect virtually universal health insurance. These three include (1) special health insurance for the poor and related groups through an insurance pool administered by private carriers and financed in part by Federal and State general revenues; (2) a catastrophic medical insurance program that would cover unusually high medical costs, on a graduated basis according to family income, financed by Federal and State general revenues; and (3) provisions designed to encourage employment-related health insurance plans to extend coverage to additional employees and improve ambulatory (out-of-hospital) health benefits.

Plan for the Poor and Related Groups

Coverage

Three groups would be covered--the poor, near-poor, and uninsurable persons. The poor and near-poor are defined as families with income below a specified amount, which would depend on the number of dependents in the family. Uninsurable persons are those rejected for health insurance coverage or offered coverage only at a high premium rate. Participation of eligible persons would be voluntary but the States would be required to cover their cash welfare recipients.

Benefits

A uniform health insurance plan would be established in each State. The State plan would need to meet certain minimum benefit standards specified in the Federal legislation. The following benefit package is shown in the proposal, but merely as an illustration of a possible State uniform plan:

Physician office visits (12 per year)
Physician services in hospital
Dental services for children age 8-14
Immunizations for children under age 8 and pregnant women
Surgery and anesthesia
Diagnostic X-ray and laboratory services
Hospital inpatient care (31 days)
Nursing home care (60 days)
Home care services (90 visits)

Administration

The State uniform plan would be administered through an insurance pool, in which all carriers would participate, that would be supervised by the State insurance agency. The pool would be administered by an insurance carrier (or group) selected by the State government, with the concurrence of the Secretary of HEW.

Payment to providers of service

There would be no change, as a result of the plan, in the methods by which insurance carriers reimburse providers of service.

Financing and costs

The poor would pay no premium for their health insurance, the near-poor would pay part of the premium, and the uninsurable would pay a rate reflecting, to some extent, their high claims cost. These premiums would be paid into the insurance pool but would be insufficient to meet necessary costs because none of the three groups would be paying a sufficient amount to meet the cost of their own benefits. Each year an actuarial determination would be made of the deficit of the pool and the State and Federal governments would share the cost of keeping the pool financially sound. The Federal share would be 65 to 90 percent, depending on the per capita income of the State.

Catastrophic Medical Insurance

Under this part of the Pettengill proposals, Federal legislation would be enacted to encourage States to establish catastrophic medical insurance plans. These plans would pay the medical expenses of families whose expenses exceed a specified amount (referred to as the annual deductible) and this deductible would vary according to family income and number of dependents. For the poor no annual deductible would be applicable (and thus the plan would pay for all covered medical expenses) but the deductible would rise rapidly as family income increased. For purely illustrative purposes, the proposal includes the following schedule of deductibles that a family of four would need to meet before benefits would be payable: $300 at the $4,000 family income level, $1,100 at the $5,000 level, $4,100 at the $8,000 level, $6,100 at the $10,000 level, and $11,100 at the $15,000 level.5/ This schedule of deductibles is designed to encourage the purchase of private health insurance which would at least cover these deductible amounts.

The program would be phased in over a period of time, both for the types of medical expenses included and the population covered. The Federal standards would indicate the types of medical expenses that would be included for the purpose of the catastrophic plan and the population groups eligible for coverage (which initially would include the poor and later the near-poor and the general population). The

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5/ Under this illustrative formula, the deductible would be calculated as follows: family income would be calculated by subtracting from gross income $600 for each Federal income tax exemption; for family income (as adjusted this way) of less than $1,000 the deductible would be zero; for family income of $1,000-$1,999, the deductible would be 50 percent of the income over $1,000; for family income of $2,000 or more, it would be $500 plus 100 percent of the income over $2,000.

program would be financed by the State and Federal Governments from general revenues with the Federal Government bearing 43 3/4 percent to 67 1/2 percent of the cost in each State, depending on the State per capita income.6/

Employment-related Health Insurance

Under the provisions designed to encourage improvement of employment-related health insurance plans, the employer could not deduct his full expenses for health insurance as permitted under present tax law (but rather only one-half of his expenses) unless the plan met certain standards with regard to coverage and benefits. Under the coverage standards, the plan would need to cover the following groups with no increase in regular employee contributions, except where indicated:

a) All full-time employees and part-time employees who work at least a specified minimum time.

b) Employees on layoff or labor dispute with coverage to continue a minimum of one month (and up to 11 additional months if employees pay the full premium).

c) Employees not working because of illness, with coverage to continue for a period of 6 months and, if permanently disabled, until eligible for social security benefits.

d) Dependent children of employees who became disabled before age 19.7/

With regard to benefits, all employment-related plans would be required to provide ambulatory (out-of-hospital) medical care benefits within a reasonable period (perhaps 5 years) after enactment of the legislation.

6/ Costs to Federal and State Governments under the two proposals described above are not available and would of course depend on income limits established under the plans, the benefits included, and other specifications not yet decided.

7/ Under private health insurance, coverage of dependent children ordinarily terminates at a specified age, usually 18 to 21.

COMPARISON OF PROPOSALS AND BIBLIOGRAPHY

The comparison of proposals was designed to provide a short summary of the features of each proposal and permit comparison among the proposals of their principle provisions. It might be noted that, for the three proposals financed from earnings taxes and general revenues, the tax rates on various sources of earnings and income are presented as a percent of taxable earnings. It should be recognized, however, that the amount of earnings or income subject to these tax rates varies among the proposals, as indicated by the information of taxable earning and income given in the comparison.

The attached bibliography is intended to provide a source of reference for those who wish to obtain further information on the five proposals included here, on additional proposals and on the general subject of national health insurance. The bibliography includes the major bills, testimony and source documents relating to each of the five proposals. The inclusion of other references, culled from the extensive literature available on the subject, was necessarily on a selective and somewhat arbitrary basis.

COMPARISON OF FIVE PROPOSALS FOR NATIONAL HEALTH INSURANCE

SUBJECT	GRIFFITHS BILL	COMMITTEE FOR NATIONAL HEALTH INSURANCE
GENERAL APPROACH.....	Government universal health insurance program financed by payroll tax and general revenues.	Government univeral health insurance program financed by payroll tax and general revenues.
COVERAGE.....	U.S. residents..	U.S. residents.
BENEFITS.....	Comprehensive health benefits. Major exclusion is dental services for adults. No cost-sharing except for physician, dentist, and other ambulatory services. ($2 copay per visit, with certain exceptions.)	Comprehensive health benefits. Major exclusion is dental services for adults. Limitations on drugs and nursing-home and mental health care. No cost-sharing.
ADMINISTRATION.....	Federal board composed of HEW officials and nongovernment members; regional offices; advisory bodies.	Federal board under Department of HEW; regional offices; advisory bodies.
PAYMENT OF PROVIDERS.....	Physician and dentist groups can contract to receive predetermined payment and pay their members as they choose (including fee for service). Individual primary physicians and dentists may elect per capita, salary, or combination of methods and receive an allowance to pay for services of specialists and other health professionals. Hospitals: Negotiated budget that includes allowance for nursing-home and home health services.	Physicians and dentists: Regional funds allocated first to those in group practice or selecting capitation, salary, or per session basis. Residual allocated to local payment authorities to pay those selecting fee-for-service or per case basis. Hospitals, nursing homes, home health agencies: Negotiated budget designed to pay reasonable cost under efficient organization.
FINANCING.....	Tax equal to 7 percent of payroll, including 1 percent on employees, 3 percent on employers, and a payment from general revenues equal to 3 percent. Earnings base of $15,000, adjusted automatically to increases in wage levels.	Tax equal to about 7-3/4 percent (on 1969 basis) including 2.8 percent on employers, 1.8 percent on employees and on nonwage income, and general revenues payment equal to 3.1 percent. Tax levied on first $15,000 of employees and nonwage income combined, and on total payroll for employers.
COST.....	Cost would have been $35.8 billion in fiscal 1969, according to AFL-CIO.	Cost would have been $37 billion in fiscal 1969, according to CNHI.

1/ Participants in approved employer-employee health plans and persons purchasing approved private insurance may remain outside of government plan and be exempted from payroll taxes.

2/ Amount of tax credit would be graduated from 100 percent to 10 percent, depending on the amount of tax

COMPARISON OF FIVE PROPOSALS FOR NATIONAL HEALTH INSURANCE

JAVITS BILL	AMA MEDICREDIT	PETTENGILL PROPOSAL
Government universal health insurance program (similar to Medicare) with option of "electing out" by purchase of private insurance.1/	Income tax credits to offset cost of qualified private health insurance.2/	Private insurance for poor or related groups through an insurance pool subsidized by government.3/
U.S. residents.	U.S. residents (voluntary).	Poor, near poor, and uninsurables (voluntary).
Same as Medicare (hospital, physician, nursing home, etc.--subject to cost-sharing and limitations). Also, annual check-ups, limited drugs, and dental care for children under age 8.	To be qualified, policy must include basic hospital and physician benefits, and may optionally offer supplementary drug, blood, hospital, and other benefits. Benefits subject generally to cost-sharing and limitations.	Statewide uniform benefits. Minimum benefits to be specified in Federal law and to include ambulatory and institutional care.
Department of HEW (as under Medicare) or, under contract with HEW, by State government. Processing of claims conducted by private carriers (as under Medicare) or, under certain conditions, by spedial quasi-government organizations.	Federal advisory board (including HEW, IRS, and nongovernment members) to establish Federal standards for use by State insurance departments in approving private insurance plans.	Statewide insurance pool administered by carrier selected by State with concurrence of Federal Government.
Until July 1, 1973, reasonable cost for hospital and institutions and reasonable charges for physicians (as under Medicare). Thereafter, new methods, developed in interim, may be employed.	Present methods under private insurance.	Present methods under private insurance.
Tax equal to 10 percent of payroll, including 3.3 percent on employers and 3.3 percent on employees and payment from general revues equal to 3.3 percent. Tax levied on $15,000 earnings base for employees and on total payroll for employers.	Financed from Federal general revenues.	Poor would pay no premium and the near poor and uninsurables would pay part of the premium. State and Federal general revenues would finance the balance of the cost of the program.
Cost of $66.4 billion in 1975, according to Social Security actuary.	Net cost for 1970 estimated at $8 billion by AMA and at $15 billion by SSA.	Estimates not available.

liability on tax return. The maximum (100-percent) credit would be an amount equal to the premium cost of a qualified health insurance policy.

3/ Proposal also provides (a) a catastrophic protection plan, geared to family income, for the general population, and (b) encouragement for additional coverage under employment-related health insurance.

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Attachment #2: Forum 11, 1970 White House
Conference on Children and Youth

NATIONAL HEALTH INSURANCE: MAJOR PROPOSALS AND ISSUES

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Debate on the subject of national health insurance for the American people has ebbed and flowed for nearly sixty years.[1] On several occasions public opinion polls have indicated a small majority in favor of some such scheme.[2] Legislative proposals have been repeatedly introduced into Congress. But none has been voted out of committee. With the passage of Medicare in 1965, probably the majority of both proponents and opponents of national health insurance believed that the issue had been settled, at least for a decade or so.

On the contrary, the issue became livelier, last year, in terms of "realpolitik," than at any time in the past. The principal reasons are evident: the apparently uncontrollable rise in health care costs – a rise that is threatening the viability of some of our major health care institutions as well as the ability of many consumers to pay, the difficulties faced by many private health insurance carriers in just maintaining the present level of benefits let alone improving benefit coverage, the general popularity of Medicare, the crisis in Medicaid and its implications for state, local, and even national politics.

Once again, as in the case of Medicare, labor has led the way. The AFL-CIO has never altered its position in favor of extension of Medicare to the entire population. In February 1969 the United Automobile Workers, a union that has long played an aggressive and constructive role in the effort to expand both public and private health insurance, set up a Committee for National Health Insurance, headed by UAW President, Walter Reuther, and consisting of such diverse and influential figures as Dr. Michael DeBakey, Mrs. Mary Lasker, Senator Edward Kennedy, Dr. Martin Cherkasky, Director, Montefiore Hospital, New York City, William S. Cowles, Jr., President, Board of Trustees, Medical Center Hospital of Vermont, John K. Galbraith, Harvard University, William Haber, University of Michigan, and Whitney Young, Jr., Executive Director, National Urban League, as well as Isidore Falk, Professor Emeritus of Public Health, Yale University School of Medicine, and other veterans of health insurance battles of the past.[3]

Labor's influence was also prominent in the report of an advisory committee to the Special Senate Committee on Aging, submitted in July 1969. Both the report and its authors, the lead-off witnesses at the committee hearings, endorsed the concept of national health insurance as well as calling for many reforms in the existing Medicare program.

Governor Rockefeller, who has suffered more from the Medicaid confusion than any other governor, came out for a national insurance scheme early in 1969. Previously, he had unsuccessfully urged compulsory health insurance for most employed persons in New York State. Prodded by Rockefeller, but clearly with an eye to their own growing welfare and Medicaid problems, the National Governors' Conference, meeting in Colorado Springs in September, endorsed the general principle of national health insurance along with the recommendation that the federal government take over all welfare costs.

Perhaps the most significant aspect of the current debate, however, is that this time, the major provider organizations are not in opposition – at least not to the general idea. The AMA has been on record with its own brand of national health insurance – known as "Medicredit" – since 1968, a position reaffirmed by the AMA House of Delegates in

1969, and by Dr. Russell Roth, Speaker of the House, in testimony before Congress last November.[4] In September, 1969, Dr. Edwin Crosby, Executive Vice President of the AHA, announced that a Special Committee on Provision of Health Services (Perloff Committee) would undertake a study of national health insurance, along with related issues, with instructions to report by February of this year.[5]

In September, the Nixon Administration instructed the McNerney Task Force on Medicaid and Related Programs, set up in July, to also study the problem of "long-term methods of financing the Nation's medical care" and develop recommendations for the Secretary of Health, Education, and Welfare.

In October came the much-publicized New York City conference of the Reuther Committee. Mr. Reuther and Dr. Falk revealed the general outlines of their thinking but many observers found the proposal surprisingly nonspecific and the entire conference unexpectedly low-keyed and non-propagandistic. The same was true of the AFL-CIO Washington Conference in November.

Early in November the House Ways and Means Committee held hearings on the Social Security Amendments, including Medicare and Medicaid. Reuther and other spokesmen for both labor groups strongly endorsed national health insurance but spent most of their time calling for specific improvements in Medicare, Medicaid, and the income maintenance programs. Perhaps the strongest plea for a new health financing program came from the AMA.

Meantime a subcommittee of the McNerney Task Force struggled with its assignment but, thus far, has submitted no recommendations. Neither has the AHA Committee given any indication of its thinking.

Thus the push for national health insurance, which appeared to be snowballing at such an unexpected rate through the summer of 1969, appears to have tapered off just as unexpectedly in the late fall – just at the time when the labor conferences and the Ways and Means Committee Hearings might have been expected to provide the perfect crescendo.

While rumors persist as to this or that proposal being worked on and this or that Senator who is polishing up his health insurance bill, it seems clear that other issues have taken precedence both in Washington and Albany. In short, it appears as though the prospect of moving from the propaganda stage to the possibility of success has given pause to some of the leading advocates of national health insurance and may lead to a new mood of serious reappraisal of its potential drawbacks – especially the likelihood of serious inflation given the existing manpower and other shortages and the danger of promising more than the existing health care economy can deliver.

To some impatient advocates of "the instant solution" this new and more cautious mood – especially on the part of erstwhile proponents – may appear foot-dragging. But to me it seems very fortunate. What is needed now is serious and in-depth study of the entire problem: not just the shortcomings of the existing financing mechanisms which up to now have been so heavily stressed in making the case for a national governmental program, but a serious effort to assess the probable results – both good and bad – of the various proposals that are being advanced and then an effort to tot up the balance. Under each of these proposals, are we likely to gain more than we lose? Or will it be the other way around? Which, if any, is more likely to lead to meaningful protection without contributing to inordinate inflation? Which is more likely to stimulate needed reforms in the organization and delivery of care?

No such advance study can be definitive. No simulation exercise, even when highly sophisticated and computerized, is fool-proof. But that is no excuse for failure to think about the consequences at all. This one reason that I welcome this meeting so much and applaud the low-keyed, educational, non-propagandistic atmosphere in which it is being held. Hopefully, it will set the tone for many similar meetings in the near future.

Three Broad Approaches

To start the ball rolling, I propose first that we try to define what we mean when we talk about "national health insurance" by sorting out and classifying some of the major approaches. I suggest three general categories: 1) national health insurance as an integral part of our national social security system, paid for primarily by payroll taxes and administered through the basic social security mechanism, in effect, extension of Medicare to the general population; 2) a program of federal subsidy of private health insurance through income-tax credits to taxpayers and federal vouchers to enable the poor to buy insurance; and 3) a program financed through some combination of payroll taxes and general revenues, with some public controls over benefits and premium rates, but underwritten or insured by private carriers.

To illustrate the first approach, I shall use a proposal advanced by Dr. Isidore Falk in his address to the American Public Health Association, November 1968.[6] Briefly, Dr. Falk would amend the Social Security Act to provide health insurance benefits for the entire population. The new system would be expected to absorb both Medicare and Medicaid. The full range of health care benefits would be provided on a service basis – rather than cash reimbursement – by private practitioners and institutions contracting with the government. There would be no deductibles, coinsurance, or arbitrary limits of any kind. The scheme would be administered by the Department of Health, Education, and Welfare. Hospitals and other institutions would be paid on the basis of costs, within specified limits, and practitioners on the basis of negotiated rates which might be fee-for-service, salary, capitation, or some combination thereof.

Two-thirds of the funds would be raised through payroll taxes, the usual social security method; one-third would be contributed directly by the federal government. Financing would be managed through the usual social security trust fund procedure and the whole scheme would be integrated, so far as possible, with the social security system. However, the entire population – not just those contributing to social security – would be eligible for benefits.

The thinking of both labor groups, as revealed at their conferences last fall, appears to follow this general approach rather closely.[7] Both aim for near universality although both foresee the probable need for some temporary limits on eligibility and benefit coverage, especially with respect to drugs and dental care. The AFL-CIO plan also provides for $2.00 co-payments for most ambulatory services.

Both emphasize the need for development of new methods of delivering care, including special incentives for prepaid group practice. The Reuther plan proposes federal standards for physician and institutional licensure. Primary care is emphasized, with the eventual goal of payment for specialist care only on referral from the family doctor.

Both plans contemplate a 2-to-1 split between payroll taxes and general revenue. The AFL-CIO suggests two percent of wage or salary for the individual, two percent of payroll for the employer, and two percent of total national payroll for the government. Under both proposals, administration would be entirely governmental; there is no provision for private intermediaries as under Medicare.

Illustrative of the tax-credit approach is the Fulton Bill[8] introduced by Representative Richard Fulton of Tennessee and incorporating many of the major features of the AMA "Medicredit" proposal. It differs from the Falk proposal in every essential respect. Not unlike some proposals advanced during the pre-Medicare debates, the Fulton plan is totally outside the social security system. Medicare would not be affected. Participation is entirely voluntary. Income-tax payers who do not participate would be penalized by losing their potential tax credits but that is altogether different from mandatory coverage.

No benefit standards are included.[9] There are no special taxes or contributions. The government contribution would be entirely out of general revenues. The object is to help individuals and families buy private health insurance through a system of graduated federal income tax credits. The credits vary from 25 to 100 percent, depending on the taxpayer's income, marital status, and type of income tax return, up to prescribed limits.

The limits are $150 a year for an unmarried person filing a separate return, $200 for a married person filing a separate return, $400 for a family unit. Individuals whose tax liability is less than the prescribed limits would be eligible for a voucher or "premium certificate" to be issued by the federal government to be used to purchase insurance. The bill also allows employers a tax credit up to 60 percent for insurance purchased for employees. A "qualified medical care insurance program" is defined as Part B of Medicare or any program providing protection against health costs without regard to pre-existing conditions and guaranteed renewable.

The third approach is frequently identified with Governor Rockefeller in recognition of his pioneer support for a version of this type of health insurance in the last four New York State Legislatures. While I have not seen the latest version, in general the Rockefeller bills have provided that all employees of firms with more than a specified number of workers – usually 2 or 3 – must be covered by health insurance, to be paid for jointly by employer and employee. Minimum premium rates, as a percentage of payroll, and minimum benefit standards are specified but the insurance could be purchased from any approved carrier. The state would make a contribution on behalf of low-income employee groups and the short-term unemployed. "Buy-in" provisions for welfare recipients are also provided.

Variations on this approach have been advanced recently by a number of knowledgeable and influential leaders of the health insurance industry. For example, J. Douglas Colman, President, Associated Hospital Service of New York, in testimony before the New York Joint Legislative Committee on the Problems of Public Health, recommended, ". . . a legislative mandate of a minimum set of health care benefits as a condition of employment with the costs shared between the employee and the employer and with some form of underwriting from tax funds for low income employees and fringe employers."[10]

Mr. Colman accompanied this general endorsement with a number of conditions that were not present in the earlier New York bills. He says that "preventive and rehabilitative services should be emphasized as well as the more costly aspects of treatment." Furthermore, the new program "should create no special barriers for, nor give any special advantage to, any single form of delivery of service." This appears to underscore the importance of providing for wide experimentation with various patterns of delivery rather than simple underwriting of the presently dominant fee-for-service solo practice.

With respect to benefits, Mr. Colman stresses the problem of reconciling desirable comprehensive coverage with existing manpower, facilities, and other inadequacies, and concludes, "I think the legislative approach to universal health care must 1) start at expenditure and benefit levels not too far distant from those now widely in use, such as the Federal Employees Program, 2) emphasize universal coverage for substantially all gainfully employed people and their dependents, 3) encourage the use of the same benefit delivery mechanisms for those not gainfully employed, and 4) be carefully designed to ensure the productive use of any new purchasing power it generates and prevent its dissipation in price rises or services that do not contribute to the health or welfare of the patient."

Edgar F. Kaiser, Chairman of the Board, Kaiser Industries and Kaiser Foundation Health Plan, in discussing the problem of health care for the indigent and medically indigent, suggested a review, ". . . of proposals made at federal and state levels as long ago as the early 1950's, when the Taft Bill and the Flanders-Ives Bill would have earmarked *variable* governmental subsidies for the indigent and medically indigent, to permit them to enroll in voluntary health insurance plans. With ingenuity and imagination government participation can be so organized that it will not defeat but will support those aspects of the voluntary insurance structure which are so advantageous to the character of our socio-economic system and of our country's people as a whole: the assurance of free choice to the consumer of personal health care, and encouragement of competition among the providers of service."[11]

Perhaps the most detailed recent proposal of this type has come from a spokesman for the commercial insurance industry. Daniel W. Pettengill, Vice President, Aetna Life and Casualty, in his testimony before the House Ways and Means Committee last Novem-

ber, advanced a two-pronged plan which included 1) federal standards for group health insurance plans, enforced by means of reduced income-tax credits to employers in case of non-compliance, and 2) federal promotion of "a uniform plan of health insurance benefits to the poor, near-poor, and uninsurable" by means of statewide "reinsurance pools" operated like a group, underwritten by all carriers in the state, administered by a single carrier, and with statutory benefit standards.[12] The "near-poor" and "uninsurables" would be required to pay something toward their insurance. Federal-state subsidies would make up the difference as well as the total cost for "the poor."

Despite the many obvious differences between the Rockefeller, Colman, Kaiser, and Pettengill proposals, they all share a middle-of-the-road area between a completely federalized scheme, on the one hand, and the completely permissive tax-credit approach, on the other. Moreover they all share certain characteristics with the second largest (next to Medicare) health insurance plan in the country – the Federal Employees Health Benefits Program. This unique program which has been in existence for nearly a decade and is successfully insuring nearly eight million persons, constitutes a creative, pragmatic, mix of public and private initiative.[13]

Unlike Medicare, a limited number of private carriers that meet federal specifications – 36 at the present time including a national Blue Cross-Blue Shield plan and a national insurance company plan – are permitted to sell the best program that they are willing to underwrite. Most carriers sell a "high" option and a "low" option. Premiums vary considerably. The government pays for all at a rate equal to nearly half the price of the low-option insurance company plan. The additional cost of the more comprehensive plans is paid by the employee thus providing some brake on rising costs and an incentive to inter-carrier competition.

Employees choose among the various plans and options and are permitted to change at specified intervals. The various insurance packages must be approved by the administrative agency, the U.S. Civil Service Commission, which also maintains continuous surveillance of the entire program. Over the years benefits under FEP have been consistently more generous than the average available to other Americans and costs lower. The *controlled competition* appears to have benefitted consumers and providers alike.

My own feeling is that the best way to characterize this third middle-of-the-road approach to national health insurance would be as an extension of the demonstrably successful FEP with modifications based on its decade of experience and, of course, the necessity of covering non-employed persons.

Comparison and Evaluation

There are obviously profound differences between these three approaches.[14] The first and third have much more in common in that participation would be compulsory, there are some controls over benefits and premiums, funds are raised primarily but not exclusively from payroll taxes, and there is a responsible administrative authority.[14a] The major difference involves private insurance versus completely public financing.

There is good historical precedent for both methods: Medicare has been successful without private underwriting as has FEP with private underwriting. On the other hand, workmen's compensation experience provides unsatisfactory experience with both. In most states, compensation insurance may be underwritten by private carriers; in a few it is restricted to state funds. Except in a few states, neither method has been really effective. The primary ingredient appears to be the quality of administration rather than the underwriting procedure – an important argument for a federal rather than a state program.

Support for the tax-credit scheme comes from two very different sources and for two very different reasons. The AMA stresses the fact that it offers no interference with the existing delivery system.[15] Economist Rashi Fein claims that it is more equitable than the social security approach because it takes into account family income and because persons of low income pay a smaller percentage of their income for the same coverage.[16]

However, Professor Fein admits there are shortcomings to this approach and concluded his recent testimony before the Joint Economic Committee with the suggestion that "we join the advantages of the progressive income-tax structure to that of the social insurance approach."

The comparative cost of the different approaches can only be estimated in the most general terms. The cost of any specific program will depend, of course, on eligibility and benefit standards, administrative procedures, and fiscal controls. However, a rough estimate of the cost of extending Medicare to the entire population, with present benefits, indicates something in the order of $20 billion a year in addition to the present $7 billion.[17] If drugs or other presently non-covered benefits were included the cost would, of course, be commensurately higher.

The cost of the proposed tax-credit plans presumably would be less since they are keyed to existing private health insurance benefits rather than the more generous Medicare. In this area some detailed estimates have been made, based on four specific proposals: the Fulton bill, the AMA's 1968 proposal, its 1969 proposal, and Professor Fein's. Taking into account differences in eligibility and methods of computing the tax credits, as well as the savings due to reduced use of Medicaid and lesser use of existing medical tax deductions, the estimates vary from $16.6 billion for the Fulton bill down to $10.8 billion for the AMA 1968 plan.[18]

To my knowledge there are no official estimates for the cost of an FEP-type program for the entire population. While it would be more expensive than the tax-credit plans it should be something less than a Medicare-type program. Hopefully, the pressure of competition would force more cost discipline – with respect both to prices and utilization – than under a single monopolistic system. As already noted, this has been the experience under FEP.

For 1966, I estimated the average cost of FEP to be in the order of $87 per capita.[19] All health care costs have of course risen considerably since then. A recent report on Kaiser – one of the most comprehensive of the FEP carriers – estimates the current average cost at $120 a year per person.[20] The comparable figure under the HIP-Blue Cross (120-day) family contract is $135.[21] On the basis of such figures, *Fortune* Magazine claims that "a good job could be done for the non-aged, non-poor population for about $175 per capita – or about one-third less than this group currently spends for the unsatisfactory care it gets."[22]

This latter point reminds us that the value of any health insurance scheme depends not only on the direct costs but on the extent to which it actually meets health needs and obviates the necessity for additional spending either by government or consumers. It is therefore essential to keep in mind that, as late as 1967, existing private health insurance met, on the average, only 33 percent of consumer expenditures for personal health care[23] and only 22 percent of total expenditures for this purpose.[24]

Despite its comparative generosity, Medicare still meets, on average, only 45 percent of its beneficiaries' health care expenditures. A substantial number must still rely on Medicaid when their Medicare benefits are exhausted. Although most of the new proposals claim they would make Medicaid unnecessary, this is unlikely. This is conspicuously true of Medicredit. Indeed, the question must be raised whether any such program, that is strictly voluntary, and has no benefit standards or administrative controls, would in the end provide any better coverage than is now available under private health insurance plus Medicaid? Does it even deserve to be called "national health insurance?"

Finally, all the programs involve the likelihood of contributing to further inflation unless accompanied by far-reaching organizational, manpower, and attitudinal changes. Again, this is particularly true of Medicredit. Even Medicare has been widely criticized on this score. In this case the fault may lie primarily with the open-ended reimbursement of providers on the basis of "reasonable costs" or "reasonable charges," as well as the anachronistic dichotomy between hospital insurance and medical insurance which Medicare took over from prevailing private practice. But many experts believe that serious inflation is unavoidable, regardless of the method of reimbursement, under any large new program

which provides neither for price competition nor public cost controls. One of the major arguments for private underwriting is that it should stimulate some degree of competition between the various carriers, as is now the case under FEP, and this, in turn, should mean some cost pressures on the providers.

Another argument in favor of an FEP-type program is that it is more likely to facilitate significant changes in the health care delivery system – a basic objective of many supporters of national health insurance. Clearly Medicredit would tend to freeze existing patterns. A national Medicare might have the same effect – no matter how much its proponents and a sympathetic administration might try to prevent this.

It is, of course, true that Medicare has made many important contributions to institutional quality controls and has given greater visibility to numerous shortcomings in the present organization of care. I yield to no one in my respect for the job done by the Social Security Administration during the past five difficult years. Like the Civil Service Commission, SSA has been characterized by stable and nonpartisan leadership and technical competence – essential ingredients in the success of both programs.

But as a device for forcing basic systemic reforms Medicare has not been effective. Witness the continuing problems experienced by Kaiser, HIP, and other "independents" in their role as Medicare intermediaries. This was almost inevitable. The larger a government program becomes, the more people and interests it affects, the more likely it is to be keyed to the least common denominator and the less flexibility it usually has to espouse minority or experimental patterns. Significantly, many of the current problems were foreseen by Kaiser officials even before Medicare became law and it is interesting to note that as early as 1965 they were urging that the new program follow the FEP pattern.[25]

In brief, the FEP-type program appears to come closest to meeting the criteria for an effective national health insurance program. Unlike the tax-credit scheme it offers the minimal controls necessary to realization of meaningful universal comprehensive coverage. While this may also be true of a universal Medicare in the long-run, in the short-run the specter of uncontrolled inflation is such as to threaten its viability. An FEP-type program appears to offer greater possibility of both short-run cost controls and long-run adjustments in the delivery system.

If, on the other hand, these hopes do not materialize; if, in fact, the private carriers prove unable to exert effective cost pressures on the providers and the necessary adjustments in delivery are not forthcoming, the decision is not irrevocable. Private underwriting can be terminated and the voluntary carriers assimilated into a governmental system far more easily than the reverse. In short, this method appears to provide maximum flexibility and maneuverability to enable the program to meet future developments without giving irretrievable hostages to fate.

Finally, even before passage of a law, I believe that the debate over such a pluralistic, competitive, program would be conducive to greater experimentation with improved methods of delivery as well as new techniques of insurance while anticipation of a single monopolistic program would contribute further to a sense of fatalism with respect to new methods and cost controls.

Taking all these considerations into account, I venture the tentative conclusion that an FEP-type federal program, suitably modified to take in the indigent and medically indigent, offers the best hope for gradual achievement of meaningful comprehensive health insurance for the entire population while retaining the very real values of consumer free choice and carrier competition which in turn should help to restrain the inevitable inflationary pressures.

Even if this general proposition is accepted, it will require a great deal of careful study and sharply-focused public and Congressional debate to work out the exact specifications of such a mammoth program. These include its relation to Medicare, the manner and rate at which it would absorb Medicaid and assimilate existing private health insurance, standards for carrier-participation, the precise technique for exercise of consumer choice, benefit levels and premium rates, and the administrative set-up. Again, however,

the FEP experience should prove highly useful.

Whatever the details, the five following characteristics appear essential:

1. Compulsory universal coverage for all not now on Medicare.
2. Statutory provision for administrative regulation of benefits and premium rates.
3. Tri-partite financing, with a large enough proportion coming from employers and employees to assure some actuarial and psychological connection between revenue and benefits, and enough from general government revenues to assure coverage of the indigent and low-income workers and to avoid the dangers of total reliance on a too-regressive payroll tax.
4. Underwriting by a limited number of private carriers, enough to assure meaningful competition among them and meaningful choice by consumers, but not too many to assure responsible administration and economies of scale.
5. Competent federal administration directed toward planning and monitoring the system in the public interest.

I offer this suggestion in the hope that it may help to reinvigorate the national debate over health insurance and contribute to making that debate as practical and realistic as possible. So long as we are "hung up" over the fear that any new federal program is likely to be disastrously inflationary and/or freeze existing unsatisfactory patterns of delivery, while failure to enact a new program can only lead to a continuing series of Medicaid fiascos we will remain immobilized, frustrated, and increasingly cynical.

There are some who feel there is no great urgency – either because there really is no immediate crisis or because it is better to wait until we can formulate a "perfect" plan. I reject both of these views. I think there is a crisis which threatens both the lives of millions of Americans and the viability of important segments of the health care economy. And I do not think we will ever achieve a "perfect" plan just by talking about it. We have to take some chances. This middle-of-the-road direction appears to offer at least a reasonable chance of success.

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2. For example, the Harris Survey reported 51 percent of the population favored "a federal plan. . . such as Medicare. . .which would cover all members of your family." *The Washington Post,* Jan. 23, 1967.

3. Committee for National Health Insurance, *Press Release,* Washington, D.C., Feb. 1, 1969. See, also, John Carlova, "Reuther's Strategy for a Health Care-Revolution," *Medical Economics,* July 21, 1969, pp. 21-31.

4. *New York Times,* Nov. 4, 1969. See, also, "The AMA Lobbies For National Health Insurance," *Medical Economics,* March 17, 1969; and *American Medical News,* Oct. 27, 1969, p. 1 ff.

5. AHA Statement by E. L. Crosby, M.D., Sept. 8, 1969, Washington, D.C.

6. I. S. Falk, "Beyond Medicare," *American Journal of Public Health,* April 1969, pp. 608-19.

7. Committee for National Health Insurance, "Tentative Specifications for National Health Insurance," Oct. 14-15, 1969; AFL-CIO, Department of Social Secruity, "Specifications for National Health Insurance," Sept. 8, 1969; also, Bert Seidman, Director, Department of Social Security, Talk to IUD Conference on National Health Insurance, Nov. 14, 1969.

8. *H. R. 9835,* introduced April 2, 1969, replacing *H. R. 19,* introduced in January. A companion bill, *S. 2705* was introduced in July by Senator Fannin of Arizona.

9. In Dr. Roth's testimony before the House Ways and Means Committee, minimum benefit standards of 60 days of inpatient care, all hospital outpatient care, and all physicians services were included. . .*American Medical News,* Nov. 10, 1969, p. 11. In private conversation with the author, some AMA officials have disassociated themselves from the Fulton Bill.

10. J. Douglas Colman, "Statement to Joint Legislative Committee on Problems of Public Health," New York City, Oct. 2, 1969, pp. 1-2.

11. E. F. Kaiser, "One Industry's Involvement in Medical Care," Paper presented to Association of American Medical Colleges, Annual Meeting, Cincinnati, Ohio, Oct. 31, 1969, p. 14.

12. D. W. Pettengill, "A Program to Improve the Availability, Acceptability, and Financing of Health Care for All in the U.S.," Presented to U.S. House of Representatives Ways and Means Committee, Nov. 6, 1969, p. 10 ff.

13. For a detailed review of FEP and comparisons with Medicare, see, A. R. Somers, "What Price Comprehensive Care?" *Archives of Environmental Health,* July 1968, pp. 6-20.

14. These by no means exhaust the range of possibilities. Nothing has been said, for example, concerning a national health service along the British model. While such a development seems highly remote in terms of U. S. attitudes at the present time, there are a few authorities who believe it is the only viable solution for the long-run. See, for example, Eveline Burns, Discussion of "Beyond Medicare," *American Journal of Public Health,* April, 1969, pp. 619-23. While Mrs. Burns does not specifically call for an American national health service, her criticism of the Falk proposal adds up to this conclusion.

14a. The Pettengill proposal does not quite fit this description. While it does provide benefit standards, participation is voluntary and its state and federal subsidies would come from general tax revenues. Under this scheme, however, most health insurance coverage would continue to be provided through private insurance and thus financed through employer-employee contributions.

15. See, for example, *American Medical News,* Oct. 27, 1969, p. 1 ff.

16. "Statement before the Subcommittee on Fiscal Policy of the Joint Economic Committee," Washington, D. C., Oct. 14, 1969, p. 13.

17. Based on the assumption that Medicare beneficiaries use 2.5 times more services than the younger population.

18. Saul Waldman, *Tax Credits for Private Health Insurance: Estimates of Eligibility and Cost under Alternative Proposals,* U. S. Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics, Staff Paper No. 3, Oct. 1969, Table B, p. 46.

19. "What Price Comprehensive Care?" *op. cit,* p. 15.

20. E. K. Faltermayer, "Better Care at Less Cost Without Miracles," *Fortune,* Jan. 1970, p. 130.

21. J. Douglas Colman, Interview, New York City, Jan. 13, 1970.

22. Faltermayer, *op. cit.*

23. L. S. Reed and Willene Carr, "Private Health Insurance in the U. S., 1967," U. S. Department of Health, Education, and Welfare, *Social Security Bulletin,* Feb. 1969, p. 22.

24. D. P. Rice and B. S. Cooper, "National Health Expenditures, 1950-67," *Social Security Bulletin,* Jan. 1969, p. 16.

25. See, for example, Clifford H. Keene, M.D., now President, Kaiser Foundation Health Plan, *Hearings before U. S. Senate, Committee on Finance on H. R. 6675,* April-May 1965, p. 459 ff. In support of his recommendation that the bill be amended along FEP lines, Dr. Keene stated:

> "From the viewpoint of promoting sound public policy, the advantages of this approach are substantial. It will effectively implement the concept of significant choices which are fundamental in our society. It will preserve the opportunity for variation and experimentation on which continuing improvements in the organization of health care services depend. It will permit different kinds of health plans to continue covering their aged members, and it will permit direct service plans to continue doing this in a manner which stresses quality medical care under a system with built-in incentives for controlling costs."